Network Notification

Date: December 7, 2012 **Number: OH-P-2012-44**

To: Ohio Providers

From: CareSource

Subject: CareSource Policy on Co-Surgeons and Modifier -62 Billing and Reimbursement

Effective: October 1, 2012

The purpose of this document is to outline the CareSource billing and reimbursement policy for Co-Surgeon claims and Modifier -62.

Policy

Using modifier -62, two surgeons

When two surgeons work together as primary surgeons performing distinct parts of a procedure, each surgeon should report the co-surgery once using the same procedure code. He/she should also report his/her distinct operative work by adding modifier -62 and any associated add-on code(s) for that procedure.

Per the AMA CPT rules for modifier -62, two surgeons may only be co-surgeons on one primary procedure, and any associated add-on codes or additional procedures if the two surgeons continue to act as co-surgeons performing distinct separate parts of the same procedure.

- **If additional procedure(s)**, including add-on procedures, are performed during the same surgical session, separate codes may also be reported with modifier -62 added.
- Per the AMA rules, the -62 modifier cannot be appended to the instrumentation or grafting codes.

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- **If a co-surgeon acts as an assistant** in performing additional procedure(s) during the same surgical session, those services may be reported using separate procedure code(s) with the modifier -80 or modifier -82 added.
- **Do not report an -80 modifier with a -62 modifier** when two surgeons are working together on co-surgery. It is implied within the description of the -62 modifier that each surgeon will be "assisting" with the procedure.
- **Report both the -62 modifier and the -50 modifier** (bilateral procedure) when co-surgery is done by surgeons of the same specialty.
- Append the -62 modifier to add–on codes the same way you would with any other co-surgery service.
- Communicate with the staff of the other surgeon billing co-surgery so claims are submitted in the same time frame.
- Each surgeon must document the separate procedures they are performing, or portions of procedures in individual op reports.
- If multiple procedures are performed, not all will necessarily meet the standard for co-surgery.
- Billing must include the supporting documentation for use of modifier -62 versus modifier -80.

Co-Surgeon Indicators

The Centers for Medicare & Medicaid Services (CMS) Co-Surgeon Indicators (CO-SURG) are found in the CMS National Physician Fee Schedule Relative Value File. Values which are currently in the CMS file are:

Value	Description
0	Co-Surgeon not permitted for this procedure.
1	Co-Surgeons may be paid; supporting documentation required to establish medical necessity.
2	Co-Surgeons permitted; 2 specialty requirements must be meet.
9	Co-Surgeon concept does not apply.

CareSource considers codes with a CMS Co-Surgeon Indicators of 1 and 2 eligible for co-surgery adjustment. Codes with a CMS Co-Surgery Indicators of 0 and 9 should not be billed with modifier -62.

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When a provider reports an eligible procedure with modifier -62 appended, reimbursement will be 125% of the established fee, divided equally between the co-surgeons. Each surgeon will be reimbursed 62.5% of the fee schedule amount.

Documentation is required for modifier -62. Additional reimbursement will only be considered when the documentation submitted clearly states the medical necessity of the co-surgery.